



Maricopa County
Department of Public Health
Division of Clinical Services

IDENTITY VERIFICATION FOR RELEASE OF INFORMATION

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1. Document Title: AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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I do hereby certify that _____ (Applicant) personally appeared before me this day and is known to me (or satisfactorily proven) to be the person whose name is subscribed to the Release of Information, and acknowledge that he/she executed the same for the purposes therein contained.

WITNESS my hand and official seal this _____ day of _____, 20____.

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